



INSTRUCTIONS FOR COMPLETING

ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS
(COMMUNITY AND FREE)

REPORT PERIOD
JANUARY 1, 2001 THROUGH DECEMBER 31, 2001

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
ACCOUNTING AND REPORTING SYSTEMS SECTION
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Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit

Instructions for Completing
Annual Utilization Report for Primary Care Clinics
for
Report Periods Ended in 2001

Table of Contents

General Instructions.....	3
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REPORTING REQUIREMENTS

Section 1 – General Information and Certification.....	5
Section 2 – Clinic Services.....	6
Section 3 – Patient Demographics	9
Section 4 – Encounters by Principal Diagnosis	13
Section 5 – Encounters by Principal Service.....	14
Section 6 – Revenue and Utilization by Payer	15
Section 7 – Income Statement	23
Section 8 – Capital Projects and Funds	27

APPENDICES

Appendix A – Primary Care Providers.....	29
Appendix B – Federal Poverty Level Guidelines	30
Appendix C - Glossary	31

**INSTRUCTIONS for
ANNUAL UTILIZATION REPORT
of PRIMARY CARE CLINICS - 2001**
Community and Free

These are the instructions for completing the 2001 Annual Utilization Report of Primary Care Clinics. Additionally, it contains a glossary of terms used within the industry.

If any of the instructions are unclear, call the Office of Statewide Health Planning and Development, Accounting and Reporting Systems Section, Licensed Services Data and Compliance Unit at (916) 322-7422 or (916) 323-7685 and ask for the Utilization Supervisor.

GENERAL INSTRUCTIONS

1. Section 1216 of the Health and Safety Code requires every licensed clinic to file with the Office of Statewide Health Planning and Development (OSHPD) an annual report that contains financial, utilization, and patient demographic information. Failure to file a timely report may result in a suspended license by the Department of Health Services (DHS) until the report is completed and filed with OSHPD.
2. The standard report period for Annual Utilization Reports covers January 1 to December 31, unless there has been a change in licensure (ownership) during the calendar year. In this case, the former licensee is responsible for submitting a final report which covers January 1 to the last date of licensure, while the new licensee is responsible for submitting an initial report which covers the effective date of licensure to December 31.

If a clinic opens or resumes operations during the year, the first utilization report would cover the effective date of licensure to December 31. If a clinic closes or suspends operations during the year, the final utilization report would cover January 1 to the date of closure.

3. All primary care clinics are required to submit their Annual Utilization Reports using OSHPD's Automated Licensing Information and Report Tracking System (ALIRTS) effective with the report period ended December 31, 2001. To use ALIRTS, clinics must have a PC with Internet access equipped with Internet Explorer (IE) Version 5.0 or higher with 128-bit encryption. IE Version 5.5 with Service Pack 1 and IE Version 6.0 are set-up for 128-bit encryption. The application will not function using Netscape. The application will function on a PC equipped with a 133 MHz processor, 32 Mb of RAM, a 28.8 bps modem, and printer. The PC and browser must be set to accept cookies and to open another window.
4. If a clinic does not have access to the Internet, OSHPD will allow it to request a modification to submit its Annual Utilization Report on a hardcopy report form. Modification requests must be made in writing and properly justified. If granted, requests will be approved on a case-by-case basis for a single reporting cycle.

5. Annual Utilization Reports are due on or before February 15 if the report is for a full 12-month report period. If the clinic closes, the report is due 14 days from the date of notification from OSHPD.

NOTE: For the report period ended December 31, 2001, OSHPD has extended the report due date for primary care clinics to September 30, 2002. This will provide OSHPD with adequate time to ensure that its new electronic reporting system is fully tested before implementation.

6. The law does not provide for any additional time to submit your Annual Utilization Report beyond the February 15 due date. However, it is OSHPD policy to allow for a 30-day extension if requested and justified. The DHS is notified of delinquent reports approximately 90 days after the February 15 due date. Please contact the Licensed Services Data and Compliance Unit at (916) 322-7422 or (916) 323-7685 if you need additional time to submit your report.

SECTION 1 – GENERAL INFORMATION AND CERTIFICATION

This section contains basic information about the clinic and parent corporation, if any, and the person completing the report. Also included is a certification to validate the accuracy of the submitted report.

1. **Lines 1 - 5: Clinic Name and Address**

The information for lines 1 through 5 is automatically entered from OSHPD's Licensing File System based on data from the Department of Health Services, Licensing & Certification Division. If you find any errors in this information, please notify us by e-mail at alirts@oshpd.state.ca.us or call (916) 323-7685.

2. **Lines 6 - 8: Facility Telephone Number, Administrator Name, and E-mail Address**

Enter the facility's main phone number on line 6 and the administrator's name on line 7. Enter the administrator's e-mail address on line 8 if one is available. The administrator's e-mail address will not be made available to the public.

3. **Line 9: Operation Status**

On line 9, check ("✓") "Yes" or "No" if the clinic was open the entire year from January 1 through December 31. The clinic is considered to be open the entire year even if closed for some holidays. Traditional holidays include New Year's Day, Martin Luther King Jr. Holiday, President's Day, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving, and Christmas. These are just some of the observed holidays that illustrate the principle that the clinic is still considered "open" for the entire year.

4. **Lines 10 - 11: Dates of Operation:**

If you answered "No" on line 9 because the clinic was not open the full year, enter the beginning and ending dates of operation on lines 10 and 11, respectively.

Example – A clinic began operation on April 15th and continued operation for the rest of the year. Line 10 would be 04152001 and line 11 would be 12312001

!! ALIRTS Note: The application will complete lines 9, 10 and 11 based on the information provided when the report was Added.

5. **Lines 12 – 17: Parent Corporation Information**

If the clinic is owned by another entity, list the name, address and phone number on lines 12 through 17. If the clinic is not owned by another entity, leave these lines blank.

6. **Lines 18 – 21: Person Completing the Report (Report Contact Person)**

The information on lines 18 through 21 will be filled in automatically based on the report preparer's registration information. However, if the person actually filling out the form is someone else, please overwrite these lines using the name, phone number, fax number and e-mail address of the person preparing the report. The e-mail address on line 21 will not be made available to the public.

7. **Certification:** The Certification is to be signed and dated by the clinic administrator after the Annual Utilization Report has been completed. The application will generate a certification that will be transmitted to OSHPD.

SECTION 2 (1) – CLINIC SERVICES

This section includes information on the community services and patient care services provided by the clinic, as well as information about languages spoken by patients and staff, and the composition of the clinic's primary care providers.

1. **Line 1: Federally Qualified Health Center (FQHC)**

On line 1, check (“✓”) if your clinic is an FQHC, an FQHC “look-alike”, or neither. These are mutually exclusive categories, you can only check one clinic type.

2. **Line 2: Rural Health Clinic (RHC)**

On line 2, check (“✓”) “Yes” or “No” if your facility is a 95-210 Rural Health Clinic.

!! ALIRTS Note: Lines 1 and 2 appear as drop-down boxes. Select as appropriate.

3. **Line 3: Community or Free Clinic (RHC)**

On line 3, check (“✓”) if your facility is a Community clinic or a Free clinic. These clinic types are mutually exclusive.

!! ALIRTS Note: The application will obtain this information from LFS and automatically place it in the header.

4. **Lines 10 – 23: Community Services**

On lines 10 through 23, check (“✓”) which Community Services are offered by the clinic. For example, if the clinic offered Adult Day Care and Transportation services, check (“✓”) lines 11 and 21.

!! ALIRTS Note: On lines 10 through 45, click in box to indicate service provided (lines 10 – 23) or language spoken (lines 30 – 45). To remove “X”, click in box again.

5. **Lines 30 - 45: Column 1: Languages Spoken by Staff**

In column 1, lines 30 through 45, check (“✓”) if one or more of your staff speaks a listed language.

Example – if your clinic has one or more staff who speaks Chinese and Spanish, you would check (“✓”) in column 1, lines 33 and 43.

Note: Do not indicate the number of staff who speak a listed language, the only acceptable entries are either a check (“✓”) or a blank. If you have four staff who speak Spanish, you would still check (“✓”) column 1, line 43.

6. **Lines 30 – 45, Column 2: Languages Spoken by Patients**

In column 2, lines 30 through 45, check (“✓”) each language in which 1% (or more) of your patient population is best served. Also check (“✓”) if 100 or more patients are best served in that language. If you don't have exact numbers, an estimate is acceptable.

Example – A clinic has a sizable population that speaks Spanish and approximately 150 patients who speak Hmong. You would check (“✓”) line 43 in column 2 to indicate the Spanish speaking population. Also you would check

(“✓”) line 35, column 2 because the population of Hmong speaking patients was estimated to be in excess of 100.

7. **Line 55: Patients Best Served in a Language Other Than English**

Enter on line 55 the **percent** of patients that are best served in a language other than English. Report percentage to nearest WHOLE percent. This figure may be an estimate based on the experience of the clinic staff, because clinics normally do not keep data on who is “best served in another language”.

Example – the staff of a clinic estimate that 50% of the clinic’s patients are best served in Spanish and 10% best served in Hmong. You would enter “60” on line 55. The only acceptable entry for line 55 is a whole number between 1 and 100. If the clinic does not have the threshold level of patients (1% or 100 individuals) for any language group, leave line 55 blank.

8. **Line 56: Designation of Language**

If there is an entry on line 55 (percentage of patients best served in another language), enter on line 56 the **name of the language** from Languages Spoken by Staff and Patients (lines 30 through 45) of the primary non-English language spoken by the clinic’s patients. If your patient population speaks primarily English, leave line 56 blank.

Example – the staff of a clinic estimate that 50% of the clinic’s patients are best served in Spanish and 10% best served in Hmong. You would enter “60” on line 55 and “Spanish” on line 56. This would indicate that the majority of the 60% non-English speaking patients were Spanish speakers. The language selected on line 56 must be one of the languages checked on lines 30 and 45.

SECTION 2 (2) – CLINIC SERVICES

FTES AND ENCOUNTERS BY PRIMARY CARE PROVIDER

The purpose of this table is to provide an accurate picture of the staffing level and volume of services delivered for each type of primary care practitioner at the clinic, regardless of the means by which they are reimbursed (or even whether they are reimbursed).

Note: For more information on counting and reporting FTEs, see “Full-Time Equivalent (FTE)” in the Glossary.

9. **Lines 60 – 74: FTEs and Encounters by Primary Care Provider**

Column 1: Salaried Provider - Enter on lines 60 through 74 the number of FTEs (to two decimal places) for each primary care provider who is salaried. The understanding in the employment agreement between primary care provider and the clinic will determine the equivalent staffing. For example, if the employment understanding were that the practitioner would work “half-time”, then the clinic would report .50 FTE for that person.

Column 2: Contracted Provider - Enter on lines 60 through 74 the number of FTEs (to two decimal places) for each primary care provider who is hired under

an hourly, daily, weekly, or other contractual relationship that is not considered a salaried relationship. Include staff who are supplied by a third-party, such as university staff sent to the clinic as the result of a contractual agreement with the university. In these cases, the hours worked must be translated to a full-time equivalent (FTE) using 2080 hours as the denominator.

Example: A physician works 16 hours per week for 52 weeks and is reported as .40 FTE as follows: Multiply 16 hours per week times 52 weeks per year to equal 832 hours per year. Divide 832 hours per year by 2080 hours per FTE to equal .40 FTE (report to two decimal places).

Column 3: Volunteer Provider - Enter on lines 60 through 74 the number of FTEs (to two decimal places) for each primary care provider who is a volunteer. The fact that the clinic does not pay a practitioner does not mean that it should not report the equivalent staffing which the volunteer represents. Calculate the number of FTEs based on the time worked during the year divided by 2080 hours.

Column 4: Total FTEs – The application will complete column 4, lines 60 through 74, with the sum of columns 1, 2, and 3 for each primary care provider.

Column 5: No. of Encounters – Enter on lines 60 through 74 the total number of encounters that were seen by each primary care provider category. As a general rule, only one practitioner can be credited with an encounter per patient per day, but there are some exceptions to this general rule. Please see the definition of “encounter” in the Glossary.

10. **Line 75: Total FTEs and Encounters**

The application will complete line 75 with the sum of lines 60 through 74 for columns 1 through 5.

11. **Lines 80 – 89: FTEs and Contacts By Primary Care Providers**

Complete lines 80 through 89 for columns 1 through 4 using the same instructions described for lines 60 through 74. In column 5, enter the number of patient contacts for each primary care provider category. By definition, the clinic services administered by these staff are not considered “encounters”.

12. **Line 90: Total FTEs and Contacts**

The application will complete line 90 with the sum of lines 80 through 89 for columns 1 through 5.

SECTION 3 – PATIENT DEMOGRAPHICS

This section reports an **unduplicated** count of all persons seen in the clinic during the report period. The total number of patients reported by Race, Ethnicity, Federal Poverty Level, Age Category, and Patient Coverage must agree. The application will not allow you to submit your report if the total patients on any one of the tables do not match the other tables.

1. **Lines 1 – 9: Race**

Enter on lines 1 through 9 the number of patients in each race category seen by the clinic during the report period.

2. **Line 10: Total Patients (Race)**

The application will complete line 10 with the sum of lines 1 through 9.

3. **Lines 11 - 13: Ethnicity**

The purpose of this table is to identify the portion of the clinic's patients that are of Hispanic background. If the clinic does not collect data on the ethnicity of its patients, an estimate is acceptable. On line 11 enter the number of patients that are of Hispanic background. Enter on lines 12 and 13 the number of patients that are non-Hispanic or unknown, respectively.

4. **Line 15: Total Patients (Ethnicity)**

The application will complete line 15 with the sum of lines 11, 12 and 13.

5. **Lines 20 – 23: Federal Poverty Level**

Enter on lines 20 through 23 the number of patients by poverty level. All patients whose income level cannot be determined may be reported as Unknown on line 23.

The purpose of this table is to report the income level of the clinic's patients based on the Federal Poverty Level. All patients must be accounted for on this table. The poverty level for a family of a given size is determined using the most recent Department of Health and Human Services Income Poverty Guidelines (Federal), which is provided in Appendix B. In cases where the clinic does not collect income-level data, an estimate is acceptable if the clinic staff is satisfied that the results are reasonable.

6. **Line 24: Total Patients (Federal Poverty Level)**

The application will complete line 24 with the sum of lines 20 through 23.

7. **Lines 30 and 31: Seasonal Agricultural & Migratory Workers**

Enter the total number of patients and encounters on lines 30 and 31, respectively that can be classified as migratory or seasonal agricultural workers, as defined below:

- **Seasonal Agricultural Worker** - an individual whose principal employment is in agriculture, typically works for a limited period of time on crops located in the area of their permanent address. These workers may establish a permanent residence in the area and commute to work. Such employment must have been within the last 24 months.

- **Migratory Worker** – an individual whose principal employment is in agriculture, whose employment in the area is typically connected to planting or harvesting a crop after which they move to another area. These workers typically do not establish a permanent residence in the area. Such employment must have been within the last twenty-four months.

8. **Lines 40 – 48: Age Category and Gender**

Enter the male and female patients in columns 1 and 2, respectively, for each age category on lines 40 through 48.

9. **Line 55: Total Patients (Age Category and Gender)**

The application will complete line 55 of columns 1 and 2 with the sum of lines 40 through 48.

PATIENT COVERAGE

The purpose of this table is to report the number of patients who were sponsored by some form of third-party coverage or were uninsured. Enter the number of patients on lines 60 through 74 by patient coverage. The three basic coverage categories are:

- **Third-Party Coverage (lines 60 – 69)** – this category includes “insurance-type” programs in which patients are enrolled, such as Medi-Cal, Medicare, or private insurance. Co-insurance or deductibles may be involved.
- **Self-Pay/Sliding Fee (line 70)** - this category includes patients who are uninsured and are responsible for his/her own coverage. These patients are expected to pay for all or some portion of the services received.
- **Free (line 71)** – this category includes patients who have met the clinic’s eligibility guidelines for charity care based on their inability to pay. Clinic services will be rendered without charge.

Patients are generally reported under the payment source that is responsible for the predominant portion of the medical payments, even if there is a secondary payer.

Example: A patient who is eligible for both Medicare and Medi-Cal is sometimes referred to as a "cross-over" patient or a “Medi/Medi” patient. In many cases, Medicare pays the first dollar and unpaid charges are ‘crossed-over’ to Medi-Cal, which pays the residual charges up to the Medicare allowable. In this example, the patient would be classified based on which payer was responsible for the predominant portion of the bill.

In cases where the coverage changes during the year, e.g., the patient changes from Medi-Cal to private insurance due to finding a job, the clinic should use the coverage at the end of the report period for classification purposes.

This table will be a "snapshot" of the patient population due to changes in coverage during the course of the year.

10. **Lines 60 – 74: Patient Coverage**

Enter the number of patients on lines 60 through 74 by patient coverage.

11. **Line 75: Total Patients (Patient Coverage)**

Line 75 will be automatically completed with the sum of lines 60 through 74. Each person treated by the clinic during the year must be accounted for in this table even if their only encounter was reported under Episodic Programs (lines 80 – 90).

Example: Mr. Jones, who is not enrolled in any type of insurance program, is treated by the clinic. Because his income is less than 200% of the federal poverty level, the clinic bills the EAPC program and is paid. This is Mr. Jones only encounter with the clinic during the year. He would be counted as a Self-Pay/Sliding Fee patient on line 70 and an EAPC patient on line 82 of the Episodic Program table.

EPISODIC PROGRAMS

This table is a patient count for each of the programs that do not enroll persons in an insurance-type relationship. All patients listed in Episodic Programs will also be accounted for in the Patient Coverage table, thus this table is a duplicate count. Count all patients whose encounters are:

- paid for by programs that target specific diseases or conditions, such as the Breast Cancer or Diabetes Programs, or
- paid for by programs that sponsor low-income patients, but do not enroll these patients, such as the EAPC program.

Each program will be credited with a patient if they paid for at least one encounter during the year.

Each patient listed in the Episodic Program table must also be accounted for in the Patient Coverage table.

Example 1: A Medicare patient has one encounter with the clinic during the year in which a breast exam was paid for by the BCCCP program. In that case the BCCCP program would receive a patient count of “1” on line 80. That same patient would also be counted in the Medicare program on line 60 of the Patient Coverage table – even though Medicare did not pay for an encounter during the year. The logic is that the patient is enrolled in Medicare and did receive services in the clinic during the year.

Example 2: A patient with no insurance coverage is treated and the EAPC program reimbursed the clinic. The patient must be counted on the Patient Coverage table as Self-Pay/Sliding Fee on line 70 and on the Episodic Program table as EAPC on line 82.

Note that the reversal is not true. Not all patients counted on the Patient Coverage table must be accounted for on the Episodic Program table.

Example: A Medi-Cal patient is seen by the clinic but never participates in one of the episodic programs. In this case the Medi-Cal program would be given credit

for the encounter on line 62, but nothing would be reported in the Episodic Program table.

The Episodic Programs Table could have zero (0) episodic patients or even a higher number of patients reported than the Patient Coverage table (if every patient were seen by more than one episodic program).

12. **Lines 80 – 89: Episodic Programs**

Enter the number of patients in which the listed program paid for one or more encounters during the year. Patients can be listed in more than one program. For example a person could have one encounter paid for by the BCCCP program and a second encounter paid for by the EAPC program. In such a case, the patient would be counted under both programs.

13. **Line 90: Total (Episodic) Patients**

The application will complete line 90 with the sum of lines 80 through 89. It is a duplicate count and does not tie to any other table.

14. **Line 95: Child Health and Disability Prevention (CHDP) Assessments**

Enter the number of CHDP assessments performed during the report period by the clinic on line 95.

SECTION 4 - ENCOUNTERS BY PRINCIPAL DIAGNOSIS

This section contains the total number of encounters by principal diagnosis and must equal the total number of encounters in Encounters by Primary Services (section 5, line 45, column 1), FTE's and Encounters by Primary Care Provider (section 2(2), line 75, column 5), and Revenue and Utilization by Payer (section 6(2), line 1, column 19). If the total number of encounters does not match in these sections, the application will not allow you to submit your report.

1. Lines 1 – 19: Encounters by Principal Diagnosis

Enter the total number of encounters on lines 1 through 19 by the principal diagnosis according to the ICD-9-CM diagnoses groups. Use lines 1 through 18 to report medical diagnoses and line 19 for all dental diagnoses. For clinics that use the ICD-9-CM codes to record their dental diagnoses, report the ICD-9-CM dental diagnoses on line 19.

Do not report the secondary or any subsequent diagnoses for any encounter (thus there is only one diagnosis for each encounter). The diagnoses groups are the same as the chapters in the ICD-9-CM coding book.

2. Line 25: Total Encounters (Diagnosis)

The application will complete line 25 with the sum of lines 1 through 19.

SECTION 5 (1) - ENCOUNTERS BY PRINCIPAL SERVICE

This table classifies each encounter by its CPT (Common Procedural Terminology) code. Enter only the primary procedure code to classify encounters. Do not report secondary or subsequent procedure codes, meaning each encounter is to be counted only once.

The total encounters on line 45 must agree with the total number of encounters reported on Encounters by Principal Diagnosis (section 4, line 20, column 1), FTEs and Encounters by Primary Care Provider (section 2(2), line 75, column 5), and Revenue and Utilization by Payer (section 6(2), line 1, column 19).

1. **Lines 1 – 30: Classification of Diseases and/or Illnesses**
Enter the total number of medical encounters using the CPT code groups on lines 1 through 30.
2. **Line 31: Family Planning “S” Code**
Enter the total number of encounters in which the primary service reported was a family planning “S” code.
3. **Line 32: Dental Encounters**
Enter the total number of encounters in which the primary service provided was dental.

Note: Report all dental procedures on line 32, even if the CPT codes are used by the clinic for recording dental procedures.
4. **Line 44: All Other Encounters**
Enter all encounters on line 44 that cannot be classified on lines 1 through 32.
5. **Line 45: Total Encounters (Procedures)**
Line 45 will be completed with the sum of lines 1 through 44 by the application.

SECTION 5 (2) - SELECTED PROCEDURE CODES

This table includes data for selected CPT codes that are of particular interest. Unlike the previous table, the procedure codes listed here do not have to be the primary service code. Enter the number of encounters for each of the defined CPT codes (or range of codes).

Example: A child comes to the clinic for the first time and receives an initial evaluation by the physician. At the same encounter, the patient is given a Hib vaccine. The evaluation was CPT-coded as “99201” and would be reported on line 1 of the Encounters by Principal Service (and that would be the only thing counted for that table). However, the secondary CPT code of “90645” (Hib vaccine) would be recorded on line 61 of this table.

6. **Lines 50 – 69: Selected Procedures**
Enter the number of procedures on lines 50 through 69 in which the given CPT code was either the primary or secondary procedure code.

SECTION 6 (1) & (2) - REVENUE & UTILIZATION BY PAYER

This section includes the encounters, gross revenues (charges), write-off's, and net patient revenue for each of the clinic's payment sources. These data are totaled in column 19.

NOTE: Free clinics do not have to complete this section, but may do so if they have the data. In order to report Free/Complimentary write-offs (charity care) on line 4, Free clinics must record and report gross revenue (charges) at full-established rates on line 2.

ENCOUNTERS

1. Line 1, Columns 1 - 19: Encounters

Enter the number of encounters for each payer source on line 1. Each encounter is classified according to the program that is the "primary" payer for the encounter. This is typically the program that is the predominant payer, i.e., responsible for 51% or more of the bill.

Example: A patient is enrolled in both Medicare and Medi-Cal. The patient receives an examination at the clinic. Medicare is billed and pays 60% of the charges. The clinic then bills Medi-Cal for the residual and Medi-Cal pays up to the Medi-Cal "maximum allowable" for the procedure. This would be counted and reported as a Medicare encounter because that program is the predominant payer for the patient's medical bill.

Column 1: Medicare – report all Medicare encounters that were reimbursed by the traditional fee-for-service method.

Column 2: Medicare Managed Care – report all Medicare encounters that were reimbursed under the terms of a managed care contract funded in whole or in part by Medicare.

Column 3: Medi-Cal - report all Medi-Cal encounters that were reimbursed by the traditional fee-for-service method.

Column 4: Medi-Cal Managed Care - report all Medi-Cal encounters that were reimbursed under the terms of a managed care contract funded in whole or in part by Medi-Cal.

Column 5: County Indigent/CMSP/MISP - report all encounters that were reimbursed by a County program regardless of whether it is a traditional fee-for-service payment or a managed care contract. These patients are considered indigent and are the responsibility of the county.

Column 6: Healthy Families - report all encounters that were reimbursed by the Healthy Families program. These patients are not considered Medi-Cal but are typically sponsored by a managed care health plan under a contract with the county.

Column 7: Private Insurance - report all encounters that were reimbursed by a private insurance program that covered the patient.

Column 8: Self-Pay/Sliding Fee - report all encounters for patients who were uninsured and responsible for paying the full amount of charges or a discounted amount. A patient who has insurance but elects to pay by cash would also be included here. These patients do not meet the clinic's charity care eligibility guidelines and therefore, do not qualify for free care. In some cases these patients may qualify for a discount of the fees based on their ability to pay. These discounts are known as sliding fee scale discounts.

Column 9: Free – report all encounters for those patients who met the clinic's charity care guidelines and are not being billed for any services. These patients are identified at the time of service as being eligible for 100% free care. Do not include patients who were able and responsible, but unwilling, for paying, or patients whose third-party coverage was denied after billing.

Column 10: Breast Cancer Programs – report all encounters in which one of the breast cancer programs were billed. Examples of these programs are the Breast Cancer Early Detection Program (BCEDP) and the Breast and Cervical Cancer Control Program (BCCCP).

Column 11: CHDP– report all encounters in which the Child Health and Disability Prevention program was billed.

Column 12: EAPC – report all encounters in which the Expanded Access to Primary Care program was billed.

Note: these are visits that would have been reported to the EAPC auditor and would meet all of the requirements of the EAPC program. All required lab work and pharmacy would have to be covered.

In some cases a clinic may “book” an encounter with no source of payment as EAPC after the clinic has exhausted its EAPC grant in order to qualify for additional funding. Such encounters should be counted as EAPC encounters **only** if the clinic is willing to pay for the additional services required by the program (lab, pharmacy. etc).

Column 13: Family PACT – report all encounters in which the Family PACT program was billed.

Column 14: San Diego Co. Medical Plan – report all encounters in which the San Diego County Medical Plan program was billed. This column should be completed only by clinics located in San Diego County.

Column 15: LA Co. Public Private Partnership – report all encounters in which the Los Angeles County Public Private Partnership program was billed. This column should be completed only by clinics located in Los Angeles County.

Column 16: Alameda Alliance for Health – report all encounters in which the Alameda Alliance for Health program was billed. This column should be completed only by clinics located in Alameda County.

Column 17: Other County Programs – report all encounters in which a county program not listed above has reimbursed the clinic.

Column 18: All Other Payers – report all encounters in which a program not listed above has reimbursed the clinic.

2. **Column 19: Total Encounters**

The sum of columns 1 through 18 will be entered in column 19 by the application.

The total number of encounters in line 1, column 19 must equal the total number of encounters in Encounters by Principal Diagnosis (section 4, line 20, column 1); Encounters by Primary Services (section 5, line 45, column 1), and FTE's and Encounters by Primary Care Provider (section 2(2), line 75, column 5). If the total number of encounters does not match in these sections, the application will not allow you to submit your report.

GROSS REVENUE

3. **Line 2, Columns 1 – 19: Gross Revenue**

For each payment source, enter on line 2 the amount of Gross Revenue, which is defined as total charges at the clinic's full-established rates (usual customary charges) for primary care services before deductions from revenue are applied.

Gross Revenue - is also referred to as "charges". These charges must be valued and reported according to an overall charge structure established by the clinic, and must be applied uniformly to all patients and payers. Gross Revenue is **not** the amount reimbursed by the third-party payer. This amount is considered Net Patient Revenue and will be calculated on line 15 (line 2 minus line 10). Any differences between Gross Revenue and Net Patient Revenue must be reported on lines 3 through 9.

Example: A clinic had 5,000 Medi-Cal encounters. The total value of all procedures was \$500,000, or the sum of all the charges for the 5,000 procedures billed at their "usual and customary" rate. Medi-Cal reimbursed the clinic \$425,000. The clinic must report the full value of the charges (\$500,000) as Gross Revenue even though the amount actually paid was less due to Medi-Cal maximum allowable reimbursement.

Managed Care Payers - The amount entered for these payers should be the total charges for all procedures valued at their usual and customary rate without discounts or adjustments, even though the managed care health plan may not have been "billed" for each procedure.

4. **Line 2, Column 19: Total Gross Revenue**

The sum of columns 1 through 18 will be entered in column 19, line 2 by the application.

WRITE-OFFS AND ADJUSTMENTS

Write-offs and Adjustments are also called “deductions from revenue” and are the difference between usual and customary charges (Gross Revenue) and the amount received from patients and payers (Net Patient Revenue). These revenue deductions consist of contractual adjustments with third-party payers, bad debts, sliding fee write-offs, and free care. Also included in this category are grants that are received to directly offset the cost of providing patient care services. Such grants have a credit balance and will appear as a negative deduction from revenue.

5. **Line 3, Columns 1 – 18: Sliding Fee Scale Write-Offs**

For each payment source, enter on line 3 the amount that was “written-off” as a sliding fee because of discounts given to patients. Sliding fee scale write-off’s typically relate to uninsured patients, and is the amount of usual and customary charges which are reduced based on payment policies established by the clinic. Sliding fee scale write-offs are generally based on family income, where patients with the lowest income level receive the largest reduction. Typically the patient still has an obligation to pay for a portion of the bill and the discounted portion is written-off as a sliding fee.

Note: Not all payment programs will have Sliding Fee Scale Write-Offs.

EAPC Program: Enter on line 3, column 12 the difference between Gross Revenue (charges) for EAPC patients and the amount received from EAPC patients in the form of deductibles. (See **Example** under Step 13 on how to report EAPC payments.)

6. **Line 3, Column 19: Total Sliding Fee Scale Write-Offs**

The sum of columns 1 through 18 will be entered in column 19 by the application.

7. **Line 4, Columns 1 - 18: Free / Complimentary Write-Offs**

For each payment source, enter on line 4 the amount that was “written-off” as free or complimentary care. Patients classified as “Free” in column 9 should account for the majority of “free” care, although it’s possible for other payment categories to report “free” care. This can occur when a patient is responsible for a portion of a bill, such as co-insurance and deductibles, and is later determined to be unable to pay. Another instance is when a patient originally classified as Self-Pay (column 8) is later determined to be unable to pay for all or part of the bill.

In order to qualify as “free” care, the services must be provided to patients who qualified under the clinic’s charity care policy as being unable to pay. The determination of which patients are “free” should be based on charity care policies approved by the clinic’s board of directors.

Free Clinics: There are some clinics that are organized and licensed as “Free” clinics. These clinics should use column 9 to report their financial data and can report financial data even though a “bill” is not sent to the patient. The reporting of “Gross Revenue” allows the Free clinic to report the full amount of charity care services provided. This means that a “usual and customary” charge must first be developed.

Example – A Free clinic had 500 encounters. The Gross Revenue (charges) for clinic services were \$42,500, but none were billed to the patients or collected. Column 9 would be completed as follows:

Line 1, column 9	Encounters	500
Line 2, column 9	Gross Revenue	\$42,500
Line 4, column 9	Free/Complimentary	\$42,500
Line 10, column 9	Total Write-Offs & Adjustments	<u>\$42,500</u>
Line 15, column 9	Net Patient Revenue	\$ 0
All the other lines would be 0 (or blank)		

8. **Line 4, Column 19: Total Free / Complimentary Write-Offs**

The sum of columns 1 through 18 will be entered in column 19 by the application.

9. **Line 5, Columns 1 – 18: Contractual Adjustments**

For each third-party payer, enter on line 5 the amount of contractual adjustments. Contractual Adjustments are the differences between usual and customary charges (Gross Revenue) and the amounts received from third-party payers (Net Patient Revenue). Contractual adjustments do not apply to individual patients; thus, no contractual adjustments should be reported under Self-Pay/Sliding Fee (column 8) and Free (column 9).

NOTE: Do not report EAPC shortfalls as contractual adjustments. (See **EAPC Program** under Steps 5 and 13.)

The two basic reimbursement arrangements with third-party payers are:

- **Fee-for-Service** - the clinic enters into contractual agreements with third-party payers whereby the clinic agrees to a schedule of reimbursement rates for each procedure or encounter. The total amount of reimbursement expected under the contractual agreement is usually less than the Gross Revenues (charges). In such cases, the difference between the Gross Revenues (charges) and the revenue received is reported as a contractual adjustment.
- **Capitation (Managed Care)** - the clinic enters into a contract with a managed care health plan, where capitated payments (per member per month) are received in exchange for providing clinic services to health plan members. The Contractual Adjustment is the difference between Gross Revenue (charges) listed on line 2 and the total amount of capitated payments received, which are included in Net Patient Revenue on line 15.

NOTE: In capitated contracts, Gross Revenue (charges) must still be recorded and reported at the usual and customary rates for each service provided, even though a bill will not be rendered to the patient of the managed care health plan. Gross revenue is the sum of the fees that would have been billed for each procedure code had the clinic been using a fee-for-service reimbursement arrangement.

10. **Line 5, Column 19: Total Contractual Adjustments**

The sum of columns 1 through 18 will be entered in column 19 by the application.

11. **Line 6, Columns 1 - 18: Bad Debt**

For each payment source, enter on line 6 the amount of patient accounts receivable which were determined to be uncollectible because of a patient's unwillingness to pay. While the majority of bad debts will relate to patients classified as Self-Pay (column 8), bad debts could also arise from unpaid co-insurance and deductibles related to insured patients. By definition, patients classified as Free (column 9) should not have any bad debts. Because bad debts are classified as deductions from revenue, they are not to be reported in operating expenses.

12. **Line 6, Column 19: Total Bad Debt**

The sum of columns 1 through 18 will be entered in column 19 by the application.

13. **Line 7, Columns 5 - 18: Grants (credit balance)**

Line 7 was primarily designed to be used for the EAPC program (column 12), but may also be used in other programs if the financial arrangements and intent are similar. Similar grants would have to meet a number of criteria:

- The grant is a sum of money to pay for defined patient care services to a given patient population.
- There is the accompanying responsibility to treat a defined group of patients and the treatment for these patients may require more funding than the grant award.
- The funds are actually disbursed by the grantor based on billings for services to the patient population, or may be a lump-sum payment.

Grants do not apply to Medicare and Medi-Cal (columns 1 through 4).

EAPC Program (column 12) – Enter the amount of the EAPC grant on line 6, column 12. Because grants have a credit balance, the amount will be treated as a negative deduction from revenue by the application.

Example: A clinic has 1,398 EAPC encounters that produced Gross Revenue of \$100,000. The clinic collected \$10,000 from patients and had a \$50,000 EAPC grant.

The EAPC column (column 12) would appear as follows:

Line No.	Data element	(12) EAPC
1	Encounters	1,398
2	Gross Revenue	\$ 100,000
3	<u>Write-Offs and Adjustments</u> Sliding Fee Scale	\$ 90,000
4	Free / Complimentary	\$ 0
5	Contractual Adjustments	\$ 0
6	Bad Debt	\$ 0
7	Grants (credit balance)	(\$ 50,000)

8	Other Adjustments	\$ 0
9	Reconciliation	\$ 0
10	Total Write-Offs and Adjustments (Sum lines 3 through 9)	\$ 40,000
15	Net Patient Revenue (line 2 – line 10)	\$ 60,000

NOTE: In this example the monies collected from the patients (\$10,000), is not an entry, it only shows up as the difference between the sliding fee scale write-off (\$90,000) and the amount of the Gross Revenue (\$100,000). The \$50,000 EAPC grant reduces the write-off from \$90,000 down to \$40,000.

All EAPC encounters (and the Gross Revenues derived from them) must meet the EAPC standards. This means that the clinic would have to pay for the accompanying services over and above what the clinic itself provides such as pharmacy and laboratory services.

14. Line 7, Column 19: Total Grants (credit balances)

The sum of columns 5 through 18 will be entered in column 19 by the application.

15. Line 8, Columns 1 – 18: Other Adjustments

Enter on line 8 any other adjustments that reduce Gross Revenue and do not fit into one of the categories on lines 3 through 7. Included here are such revenue deductions as Policy Discounts (discounts provided to employees) and Administrative Adjustments (write-offs of small account balances).

16. Line 8, Column 19: Total Other Adjustments

The sum of columns 1 through 18 will be entered in column 19 by the application.

17. Line 9, Columns 1 – 18: Reconciliation

In some programs, the initial payment received by the clinic for services is an interim payment. At some point there is an audit of a cost report and the clinic is paid additional monies (or has to repay monies) based on the results of the audit. This subsequent payment is referred to as the “reconciliation payment”.

For each appropriate payer, enter on line 9 reconciliation payments that were or will be received or paid. If reconciliation payments were received or projected to be received, enter the amount as a negative (bracketed) figure. If reconciliation payments were paid or projected to be paid, enter the amount as a positive figure.

If a program includes reconciliation payments, there are two acceptable methods to record the reconciliation amount.

Accrual Method

The clinic is able to accurately determine the amount of the reconciliation payment before it is received or paid. This determination could be a percentage of accounts receivable based on previous years' experience or based on a completed cost report. Recognizing the reconciliation payment in the report period in which it is earned provides a more accurate comparison of gross revenue, net patient revenue, and expenses. If the clinic uses the accrual method, enter the calculated amount of the reconciliation payment on line 9 for the appropriate payer source.

"Cash-basis" Method

If the clinic does not have the ability to accurately determine the reconciliation payment, it should record the reconciliation payment in the report period when the actual payment was received or paid. This means that a reconciliation payment related to a prior fiscal year may be recorded and reported in the current fiscal year, and that a reconciliation payment related to the current fiscal year may be accounted and reported in the next fiscal year.

To achieve consistency and accuracy in reporting, the clinic may not use both methods, i.e., record the actual reconciliation payments received during the report period ("cash method") and make a projection of the amount likely to be received from the payer ("accrual method"). Reconciliation payments do not pertain to patients classified as Self-Pay/Sliding Fee Scale (column 8) or Free/Complimentary (column 9).

18. **Line 9, Column 19: Total Reconciliation**

The sum of columns 1 through 18 will be entered in column 19 by the application.

19. **Line 10, Columns 1 – 19: Total Write-Offs and Adjustments**

The application will complete line 10 with the sum of lines 3 through 9. Any grants on line 7 will be subtracted. These amounts represent the total revenue deductions from the Gross Revenue for payer and in total.

20. **Line 15, Columns 1 – 19: Net Patient Revenue**

The application will automatically subtract line 10 from line 2 and enter the result on line 15. These amounts represent the actual revenue received by the clinic for patient services from each payment source and in total.

SECTION 7 - INCOME STATEMENT

This section is a standard income statement that displays the sources of operating revenue for the clinic, the types of expenses required to operate the facility, and the net from operations. The definitions of both revenue and expenses are provided below and are consistent with those found throughout this report and in the healthcare industry.

1. **Line 1: Gross Patient Revenue**

Gross patient revenue on line 1, column 1 will be completed by the application using the gross revenue amount reported in section 6, line 2, column 19. This figure represents the total Gross Revenue (charges) reported by the clinic at its full-established rates for all patient care services.

2. **Line 2: Total Write-Offs & Adjustments**

Line 2, column 1 will be completed by the application using Total Write-offs and Adjustments from section 6, line 10, column 19. This figure represents the difference between gross revenue (charges) and net patient revenue (amounts received) reported by the clinic from all payment sources.

3. **Line 3: Net Patient Revenue**

Line 3, column 1 will be completed by the application using Net Patient Revenue from section 6, line 15, and column 19. This figure represents the actual revenue received by the clinic from all payment sources for patient care operations.

OTHER OPERATING REVENUE

This revenue category represents amounts received that were not reimbursements from third-party payers and patients for patient care services. While Other Operating Revenue are typically used for the purpose of underwriting clinic operations, this category also includes income from non-medical sources, such as investments and interest income. Examples include Federal grants, State contracts, and donations from private parties.

4. **Line 4: Federal Funds**

Enter on line 4, column 1 the amount of Federal grants or Federal contracts that do not relate directly to patient care services, and are provided to the clinic to underwrite its overall mission.

Do not report third-party reimbursements for patients covered by a federal program, e.g., Medicare reimbursements. (Medicare is a "payment source" and Medicare revenue is reported in section 6.)

Example: A clinic receives a \$10,000 grant from the federal government to provide community services. The grant may define the population to focus the service (e.g., patients over 65) and even define the targeted programs (e.g., patient transportation). The clinic receives the monies under the terms of the grant (\$2,500 per quarter) and must provide documentation to prove that expenses were incurred and results achieved that meet the terms of the grant.

5. **Line 5: State Funds**

Enter on line 5, column 1 all State grants or State contracts that do not relate directly to patient care services and are provided to the clinic by the State to underwrite its overall mission.

Do not report third-party reimbursements for patients covered by a State program, e.g., Medi-Cal reimbursements. (Medi-Cal is a “payment source” and Medi-Cal revenue is reported in section 6.)

6. **Line 6: County Funds**

Enter on line 6, column 1 County grants or County contracts that do not relate directly to patient care services and are provided to the clinic by the County to underwrite its overall mission.

Do not report third-party reimbursements for patients covered by a County program.

7. **Line 7: Local (City or District) Funds**

Enter on line 7, column 1 Local grants or Local contracts that do not relate directly to patient care services and are provided to the clinic by the City or District to underwrite its overall mission.

Do not report third-party reimbursements for patients covered by a local program. These amounts are reported in section 6.

8. **Line 8: Private**

Enter on line 8, column 1 private grants or contracts that do not relate directly to patient care services and are provided to the clinic by a private non-governmental entity to underwrite its overall mission.

9. **Line 9: Donations / Contributions**

Enter on line 9, column 1 funds donated to the clinic to underwrite its overall mission.

10. **Line 19: Other**

Enter on line 19, column 1 funds generated or received by the clinic that are not reported elsewhere. Revenue that was generated from non-patient care operations would be reported here. Examples include rent from properties owned by the clinic and leased out to other entities; interest income from investments; and any other type of income that was earned for non-medical services.

11. **Line 20: Total Other Operating Revenue**

The application will complete line 20, column 1 with the sum of lines 4 through 19.

12. **Line 25: Total Operating Revenue**

The application will complete line 25, column 1 with the sum of line 3 (Net Patient Revenue) and line 20 (Total Other Operating Revenue). This amount represents the total revenue received from all sources.

OPERATING EXPENSES

This portion of the Income Statement represents all expenses incurred by the clinic for the purpose of delivering patient care.

13. **Line 30: Salaries, Wages and Employee Benefits**

Enter on line 30, column 1, the total compensation for all staff employed by the clinic. This includes salaries, wages and employee benefits. In addition to payroll benefits, also included here are paid time-off, health insurance, life insurance, pension and retirement, and workers' compensation insurance.

14. **Line 31: Contract Services - Professional**

Enter on line 31, column 1 the expenses associated with medical or dental professional services purchased under contract from another entity, e.g., a physician medical group or university. This situation may arise due to the inability to hire salaried staff or because it is the most economical means to provide the service.

Example: The clinic contracts with a university that provides a physician three days per week at the clinic site. The physician is an employee of the university. The total amount of the contract is reported here.

15. **Line 32: Supplies – Medical and Dental**

Enter on line 32, column 1 the cost of consumable medical supplies that were used to provide patient care. This includes such supply items as bandages, gauze, paper gowns, disposable gloves, plastic cups, etc.

16. **Line 33: Supplies – Office**

Enter on line 33, column 1 the cost of consumable non-medical supplies that were used to operate the business functions of the clinic, but not used directly in providing patient care. Included here would be patient charts, pens, pencils, billing forms, copy paper, fax cartridges, etc.

17. **Line 34: Outside Patient Care Services**

Enter on line 34, column 1 the expenses associated with patient care services purchased under contract from another entity, such as a hospital, laboratory, or physicians group. These services are typically specialized diagnostic or therapeutic services, such as radiology or laboratory services, in which it would be uneconomical for the clinic to hire the staff and purchase the equipment in order to provide the service.

Example: The clinic contracts with a laboratory down the street to perform complex lab tests which cannot be performed on-site by clinic staff. The parties agree on a fee schedule and the lab bills the clinic for services rendered. The total amount paid to the lab would be reported as an expense here.

18. **Line 35: Rent / Depreciation / Mortgage Interest**

Enter on line 35, column 1 the total rent paid by the facility. If the clinic owns its building, then depreciation expense and interest expenses on any long-term borrowings are to be included here. Also included here are similar costs associated with equipment

that is either rented or capitalized (major movable and fixed). Minor equipment that is purchased and expensed should be reported in Supplies (lines 32 and 33).

19. **Line 36: Utilities**

Enter on line 36, column 1 the total amount paid for electricity, gas, water, sewer, telephone, internet services, and any other utility service.

20. **Line 37: Professional Liability Insurance**

Enter on line 37, column 1 the total premium paid for professional liability insurance to cover the clinic's health care professionals.

21. **Line 38: Other Insurance**

Enter on line 38, column 1 the total premiums paid for all types of insurance other than professional liability. This would include fire, flood, and general liability insurance premiums for the clinic.

22. **Line 39: Continuing Education**

Enter on line 39, column 1 the total cost of providing continuing education classes for healthcare professionals. To maintain professional licenses or certification, many healthcare professionals are required to complete minimum education requirements each year.

23. **Line 44: All Other Expenses**

Enter on line 44, column 1 all expenses that are not reported elsewhere. Included here are such expenses as travel, repair and maintenance contracts, legal and audit fees, and consulting fees, as well as allocated expenses from a home office.

24. **Line 45: Total Operating Expenses**

The application will complete line 45, column 1 with the sum of lines 30 through 44. This figure represents the total operating expenses of the clinic.

25. **Line 50: Net From Operations**

This is the net profit/loss incurred by the clinic for the delivery of patient care services. Line 50, column 1 will be completed by the application by subtracting line 45 (Total Operating Expenses) from line 25 (Total Operating Revenue).

SECTION 8 - CAPITAL PROJECTS AND FUNDS

Section 127285 of the Health and Safety Code requires all clinics to report: 1) “acquisitions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars (\$500,000)”, and 2) “commencement of projects during the reporting period that require a capital expenditure for the facility or clinic in excess of one million dollars (\$1,000,000).”

EQUIPMENT ACQUIRED OVER \$500,000

1. **Line 1: Equipment Acquired Over \$500,000**

On line 1, check (“✓”) “Yes” or “No” if your clinic purchased any diagnostic or therapeutic equipment whose cost was \$500,000 or more during the report period.

If you answered “yes”, you must complete the equipment detail on lines 5 through 8. If you answered is “no”, skip to line 10.

!!ALIRTS Note: For lines 1 and 10, select “Yes” or “No” from the drop-down box.

EQUIPMENT DETAIL

If you answered “yes” on line 1, column 1, complete lines 5 through 8, as needed. Complete these lines with individual pieces of diagnostic and therapeutic equipment, not the total sum of all equipment purchased during the report period.

2. **Lines 5 - 8, Column 1: Market Value**

Enter in column 1 the market value (purchase price) of any individual piece of equipment purchased in the last year, whose value was \$500,000 or more.

3. **Lines 5 - 8, Column 2: OSHPD Project Number**

Enter in column 2 the OSHPD Project Number of any individual piece of equipment purchased in the last year, whose value was \$500,000 or more. If an OSHPD Project Number does not exist, leave the column blank.

4. **Lines 5 - 8, Column 3: Date of Acquisition**

Enter in column 3 the date the equipment was purchased.

5. **Lines 5 - 8, Column 4: Means of Acquisition**

To indicate the means used for acquiring equipment, check (“✓”) if the equipment was purchased, leased, donated, or if other means were used.

CAPITAL EXPENDITURES OVER \$1,000,000

6. **Line 10: Capital Expenditures over \$1,000,000**

On line 10, check (“✓”) “Yes” or “No” if your clinic had capital expenditures whose cost was \$1,000,000 or more during the report period.

If you answered “yes”, you must complete the capital expenditure detail on lines 11 and 12. If you answered “no”, skip to lines 15 through 19.

7. **Lines 11 - 12, Column 1: Projected Total Capital Expenditure**
Enter on lines 11 and 12, column 1 the total projected cost of the capital project, even if some of the monies will be spent in a future year. Remember, the total project must have a projected total value of \$1,000,000 or more to be reported.
- If one qualifying purchase was made, leave line 2 blank. If two qualifying purchases were made, complete both lines.
8. **Lines 11 - 12, Column 2: OSHPD Project Number**
On lines 11 and 12, column 2, enter the OSHPD Project Number if one was assigned. If no OSHPD Project Number was assigned, leave column 2 blank.

CAPITAL FUND

9. **Line 15: Beginning Balance**
Enter on line 15, column 1 the balance of the Capital Fund at the beginning of the report period. If the clinic does not have a Capital Fund, leave the table blank.
10. **Line 16: Current Year Contributions**
Enter on line 16, column 1, the total of all contributions to the Capital Fund during the report period.
11. **Line 17 Current Year Interest Earnings**
Enter on line 17, column 1 the total of all interest that was earned by the Capital Fund during the report period.
12. **Line 18: Current Year Expenditures**
Enter on line 18, column 1 the total of all expenditures paid for by the Capital Fund during the report period. Enter as a negative amount.
13. **Line 19: Ending Fund Balance**
The application will complete line 19, column 1 by adding lines 15, 16 and 17, and then subtracting line 18.

PRIMARY CARE PROVIDERS

A. MEDICAL SERVICES PROVIDERS:

PHYSICIAN

General Practitioner
Internist
Obstetrician/Gynecologist
Allergist
Dermatologist
Surgeon
Ophthalmologist

Family Practitioner
Pediatrician
Psychiatrist
Cardiologist
Orthopedist
Urologist
Other specialists and sub-specialists

NURSES: *

Clinical Nurse Specialist
Public Health Nurse
Home Health Nurse
Visiting Nurse

Registered Nurse
Licensed Practical Nurse
Licensed Vocational Nurse
Psychiatric Nurse

MID-LEVEL PRACTITIONERS: *

Certified Nurse-Midwife
Nurse Practitioner

Physician Assistant

B. DENTAL PROVIDERS:

DENTIST

General Practitioner
Oral Surgeons
Periodontist

Pedodontist
Dental Hygienist
Oral Therapist

C. OTHER PROVIDERS:

Psychologist
Psychiatric Social Worker
Licensed Clinical Social Worker
Audiologist
Occupational Therapist

Podiatrist
Physical Therapist
Nutritionist/Dietician
Optometrist
Speech Therapist
Chiropractor

* Mid-level Practitioners and Nurses are considered providers ONLY when they act independently in the provisions of health care.

FEDERAL POVERTY LEVEL GUIDELINES

Number in Family	Below 100%	100-200%	Over 200%
1	< \$ 8,590	\$ 8,590 - \$17,180	> \$17,180
2	< \$11,610	\$11,610 - \$23,220	> \$23,220
3	< \$14,630	\$14,630 - \$29,260	> \$29,260
4	< \$17,650	\$17,650 - \$35,300	> \$35,300
5	< \$20,670	\$20,670 - \$41,340	> \$41,340
6	< \$23,690	\$23,690 - \$47,380	> \$47,380
7	< \$26,710	\$26,710 - \$53,420	> \$53,420
8	< \$29,730	\$29,730 - \$55,960	> \$55,960
9	< \$32,750	\$32,750 - \$65,500	> \$65,500
10	< \$35,770	\$35,770 - \$71,540	> \$71,540

For family units with more than 10 members, add \$3,020 for each additional member.

(These Poverty Income Guidelines were published in the Federal Register on February 16, 2001.)

GLOSSARY

AGRICULTURE:

Farming in all of its aspects, including:

- cultivation and tillage of the soil;
- the production, cultivation, growing and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in, or on, the land;
- the production of dairy products, the raising of livestock, bees, furbearing animals, or poultry; and /or
- any practice performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to carriers for transportation to market.

BIRTHING SERVICES:

Labor and delivery services for pregnant women.

COMMUNITY EDUCATION:

Services of an educational or counseling nature carried out by licensed or non-licensed staff. I.e., family planning education, nutrition, parenting, or hypertension.

COMMUNITY HEALTH CENTERS (CHCs):

Community health centers (CHCs) provide comprehensive primary health care services using a culturally sensitive, family-oriented approach. Services are available to anyone, regardless of their ability to pay. CHCs tailor their services to meet the specific needs of their community and its residents, including special populations such as the homeless, migrant and seasonal farmworkers, HIV/ AIDS patients, the elderly, residents of public housing, and chronic alcohol and substance abusers. The focus of CHCs is to provide services in the most underserved areas.

COUNTY MEDICAL SERVICES PROGRAM (CMSP):

A county indigent program where the county population is 300,000 persons or less.

CO-PAYMENT:

That portion of the bill for which the individual patient is responsible for paying.

DEPENDENTS (FAMILY MEMBERS):

A dependent is any person living in your household, as a relative or non-relative, whose gross income is less than \$2,500 annually. The head of household must provide over one-half the dependent's total support.

DIAGNOSTIC EQUIPMENT:

Equipment that helps the physician identify and determine the cause of an illness, e.g., x-ray equipment, CAT scanners, PET scanners, etc.

ENCOUNTER(s):

An encounter is recorded when a licensed practitioner (medical, mid-level medical, dental, mental health) using independent judgement, examines or treats a patient, and records the findings in the patient's chart.

The types of encounters permitted would be

- ◆ Medical (see note below),
- ◆ Nutritional
- ◆ Health Education
- ◆ Mental health,
- ◆ Dental,

Multiple encounters on the same day are possible, but they require multiple providers, a separate diagnosis or treatment plan by each provider, the plan must be prepared by a practitioner using independent judgement, and the visit must be fully charted. One provider cannot provide a medical, health educational and nutritional encounter even if the doctor saw a diabetic, adjusted his medications, warned him about eating patterns and provided him with a new diet plan to keep him more stable. Similarly when the doctor asks the nurse to do the health education portion of the encounter, the clinic does not report a medical and a health education encounter. However, if the doctor orders services from a health educator, who then sits down and does a full (separately charted) health education visit that would be considered a second encounter. If the health educator subsequently refers the patient to a nutritionist who does yet another separately charted face-to-face nutrition assessment, this would be counted as a third encounter (medical with the doctor, health education with the health educator, and nutritional with the nutritionist).

NOTE: Only one type of encounter would be allowed per patient visit to the clinic, i.e., one medical encounter per patient visit. If the patient sees both a mid-level medical practitioner and the physician on the same visit, the encounter would be recorded under the practitioner that did the majority of work on that day. Even if the patient came back a second time in the same day, only one encounter would be reported unless the second visit was for a problem unrelated to the initial encounter.

ETHNICITY - HISPANIC:

A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

EXPANDED ACCESS TO PRIMARY CARE (EAPC):

A program which provides reimbursement to primary care clinics for the delivery of expanded outpatient medical services including preventive health care, smoking prevention/cessation health education, and case management services to program beneficiaries.

FARM WORKER AND DEPENDENT (s):

See Seasonal Agricultural and Migratory Workers.

FEDERAL 95-210 Clinic:

A Federally funded, fixed-rate program applicable only to rural clinics.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC):

Federally Qualified Health Centers (FQHCs) were created in the early 1990s and are public or nonprofit, consumer-directed health care corporations. FQHCs provide high quality, cost-effective and care to medically underserved areas and populations. FQHCs are required to provide a wide range of services to receive funding, including primary and preventive services, cancer and other disease screening, well child services, eye, ear, and dental screening, family planning services, emergency medical and dental services, and some pharmaceutical services. If a particular health center does not have the capacity to provide one or more of these services directly, they must provide them through contracts or cooperative arrangements. These safety-net providers are primarily health centers that are supported by federal grants under the US Public Health Service Act (PHSA): Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, Public Housing Primary Care Programs and Urban Indian and Tribal Health Centers. FQHCs must meet rigorous federal standards related to quality of care and services, cost, and governance. They are qualified to receive cost-based reimbursement under Medicaid and Medicare law.

FEDERALLY QUALIFIED HEALTH CENTER “LOOK-ALIKE”:

Some clinics meet basic qualifications that regular FQHCs do: they are public or nonprofit, provide services to anyone regardless of their ability to pay, serve a medically underserved area or population, and have a board in which patients make up the majority. These clinics are not FQHCs because they lack the funding necessary to receive Public Health Service (PHC) grants. Instead, they are called **FQHC “look-alikes”** and receive the same cost-based reimbursement as FQHCs. Some states use look-alikes to provide health services in areas of need, even if PHS funds are not available.

FQHC:

See Federally Qualified Health Center

FULL-TIME EQUIVALENT (FTE):

For salaried positions: The understanding contained in the employment agreement shall be the determining factor when reporting FTE practitioner in the annual utilization report. If the understanding is that the practitioner is being hired as “full-time” then the clinic should report that practitioner as 1.00 FTE (use two decimal places on the form). This same logic would also apply if the understanding contained in the employment agreement specified part time employment (i.e. if the understanding was the practitioner was a “half time employee”, then he/she would be reported as 0.5 0 FTE).

Note that this definition does not make any distinction between duties the physician actually performs. Time spent on tasks associated with patient care is included in the FTE definition as well as the time spent actually seeing patients. Such functions as

making rounds, charting, arranging hospital admission, supervising mid-level practitioners or nurses or residents, participating in quality assurance, peer review or utilization, etc. would all be considered as part of the FTE. The reported FTE is based on the understanding of the physician's total work effort contained in the employment agreement. **No time is "carved out" or excluded.**

For contracted positions: A contractual employee that is reimbursed on the basis of time (hourly, daily, weekly or monthly) in which a specific rate per time is defined and the payment is based on the amount of time worked in the clinic. The time basis could be the hour, day, week or some other time frame. The employee could have a direct relationship with the clinic (such as a physician who is hired under an hourly contract) or the clinic could contract with a third party to supply staff to the clinic (i.e. the clinic would have a contract with a university which would supply staff). In these cases the hours worked (and paid for) must be translated to full-time equivalent using 2080 hours as the denominator. Thus if a physician works 16 hours per week for 52 weeks he/she would be .40 FTE.

16 hours per week X 52 weeks per year = 832 hours per year.
832 hours per year / 2080 hours per FTE = .40 FTE's (report to the second decimal place)

For volunteer positions: At some clinics unpaid staff make up a significant portion of the service delivery capability. These volunteers must be converted to full-time equivalents similar to contractually paid staff. The FTE would be calculated by dividing the hours worked per year by 2080 as you would for a position paid on a time basis (see above).

MEDICALLY INDIGENT ADULT SERVICES PROGRAM (MISP):

A county indigent program where the county population is greater than 300,000 persons.

OFF-SITE ENCOUNTERS:

These are encounters that take place in a location other than the clinic site, including the patient home (home visits), hospitals, migrant camps, etc.

ON-SITE ENCOUNTERS:

These are encounters that take place at the clinic's service site, including satellite clinics and mobile vans.

OUTREACH:

Clinic staff going into the community to inform prospective patients of the availability of the clinic services and assisting patients in obtaining these services.

PATIENT(S):

The number of unduplicated patients who received health care services from a licensed or certified provider during the reporting period. If a patient was covered by more than

one third-party during the reporting period, e.g., Medicare and Private Insurance, use the payer category that was responsible for the predominant portion of the charges.

PROVIDER:

A LICENSED or CERTIFIED individual who assumes primary responsibility for assessing the patient and exercises independent judgement as to services rendered during the encounter. See attachment "A" for a listing of Medical Providers, Dental Providers, and Other Providers.

RACE – ASIAN / PACIFIC ISLANDER:

A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

RACE - BLACK:

A person having origins in or who identifies with any of the black racial groups of Africa.

RACE - NATIVE AMERICAN / ALASKAN NATIVE:

A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

RACE – OTHER / UNKNOWN:

Any possible options not covered in the other race categories.

RACE – WHITE:

A person having origins in or who identifies with any of the original caucasian peoples of Europe, North Africa, or the Middle East.

RURAL HEALTH CLINIC (RHC):

Rural health clinics (RHCs) were created under the Rural Health Clinic Services Act of 1977 to improve access to care for underserved populations in rural areas of the country. The passage of this act provided a reimbursement mechanism under Medicare and Medicaid that reimburses for services of midlevel practitioners in RHCs. Prior to passage of this act, midlevel practitioners were not eligible for reimbursement from Medicare, or in some states, Medicaid. In order to be certified, RHCs must be located in an area that is not an urbanized area as defined by the Bureau of the Census and in a Medically Underserved Area (MUA) or Health Profession Shortage Area (HPSA).

SEASONAL AGRICULTURAL AND MIGRATORY WORKERS:**MIGRANT WORKER** (includes dependents):

An individual, whose principal employment is in agriculture on a seasonal basis as opposed to year-round employment and who, for purposes of employment, DOES establish a temporary place of residence. Migrant workers live in a work area

temporarily. Such employment must have been within the last 24 months.

SEASONAL AGRICULTURAL WORKERS (FARMWORKERS) (includes dependents):

An individual whose principal employment is in agriculture, on a seasonal basis, as opposed to year-round employment; and who, for purposes of employment, DOES NOT establish a temporary place of residence. Seasonal workers commute to work in the area of their permanent address. Such employment must have been within the last 24 months

SOCIAL SERVICES:

Assessment, referral and follow-up services to assist patients with their health and social needs. They are usually provided on an on-going basis. May include childcare, translation, legal assistance, housing, etc.

STATE LEGALIZATION IMPACT ASSISTANCE PROGRAM (SLIAG):

A program that provides funding for public assistance, public health, and educational services for newly legalized residents.

THERAPEUTIC EQUIPMENT:

Equipment that helps the provider treat a patient, e.g. lithotriptors, linear accelerators, or cardiac catheterization equipment. This term may refer to equipment that must be anchored due to safety issues.

VOLUNTEERS:

Staff that deliver services for the clinic without compensation. Typically volunteer staff work less than full-time, but may account for a significant portion of the service delivery capability. You would only count volunteers that come in on a scheduled basis. These volunteers must be converted to full-time equivalents similar to contractually paid staff. The FTE would be calculated by dividing the hours worked per year by 2080 as you would for a position paid on a time basis (see FTE).